

TELECOMMUTING ANNUAL RE-CERTIFICATION

Employee's Name	Supervisor's Name
-----------------	-------------------

Type of Telecommuting: ☐ Regular ☐ Ad hoc ☐ Medical
Regular - _____ days per week/pay period; Medical -- consult with Telecommuting Coordinator for details

For regularly scheduled Telecommuting participants, list the employee's establish work schedule below. Indicate in the last row if the work site is at the office (O) or the Telecommuting (T) site.

	Mon	Tues	Wed	Thurs	Fri	Mon	Tues	Wed	Thurs	Fri
Hour										
Start										
End										
Site										

The following checklist is designed to help you assess an employee's eligibility to continue in the arrangement.

1. Do the work assignments of the employee's current position warrant continued participation? ☐ No ☐ Yes
2. Is the employee's most recent performance rating Fully Successful or higher? ☐ No ☐ Yes
3. Does the employee demonstrate the ability to work independently? ☐ No ☐ Yes
4. Is the employee able to maintain the quality and quantity of his or her work? ☐ No ☐ Yes

☐ Approved ☐ Disapproved: **REASON:**

I have reviewed and discussed the re-certification criteria and decision with the employee.

Supervisor's Signature:	Date:
Employee's Signature:	Date:

Distribution

If approved:

Original-Attach to the original telecommuting agreement
Copy to-Employee's Supervisor
Servicing Personnel Office

If disapproved:

Original-Employee
Copy to-Employee's Supervisor
Servicing Personnel Office